



# Stay at Work Wage

## Reimbursement Application for Employers

Apply separately for **expense** reimbursement.

### ▼ Employer:

Business Name:	Name:
L&I account #:	L&I Claim #:

### ▼ Injured worker:

### ▼ Make reimbursement payable to:

Name of company or person		
Mailing Address		
City	State	Zip

### Employer:

- Find out if you're eligible.
- Learn about required documentation. **See pg. 2.**



### ▼ Job before injury description:

Example: <i>Warehouse worker - Produce packing</i>	Example: <i>Inventory control clerk</i>
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### ▼ Light-duty or transitional job description

### ▼ Information we need to calculate your wage reimbursement

Do not include tips, commissions, bonuses, board, housing, fuel, health care benefits, or any other payments.

<b>Choose the best time period</b> that covers your request:  <b>For example:</b> <ul style="list-style-type: none"><li>• Your usual payroll period.</li><li>• Weekly, bi-weekly, or monthly.</li><li>• From start to finish of light-duty or transitional work.</li></ul> <i>It's up to you.</i>	<b>1. Time period worked in light-duty or transitional job:</b> ____/____/____ to ____/____/____ Worked swing or graveyard shift? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Base wage you paid injured worker for light-duty or transitional work:</b>  <b>Base wage rate:</b> \$ _____ per _____ hr/day/wk/mo.
	<b>2. Total # of days employee actually worked</b> in above time period: _____. (Don't include vacation/sick leave/etc.)	<b>Total base wage paid</b> \$ _____ for light-duty this period:
	<b>3. Circle dates <u>actually worked</u> below.</b>	<b>50% reimbursement amount</b> \$ _____ you are requesting:

### ▼ Fill in month/year and circle light-duty or transitional dates worked:

Month: \_\_\_\_\_ Year: \_\_\_\_\_

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
18	19	20	21	22	23	24	25	26	27	28	29	30	31			

Month: \_\_\_\_\_ Year: \_\_\_\_\_

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
18	19	20	21	22	23	24	25	26	27	28	29	30	31			

Month: \_\_\_\_\_ Year: \_\_\_\_\_

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
18	19	20	21	22	23	24	25	26	27	28	29	30	31			

▼ Sign below to confirm this information is true and accurate.

**Important:** List of required documents on pg. 2.

Employer's signature
Title
Phone #
Date (mm/dd/yyyy)

► Do you still employ this worker? ☐ Yes ☐ No If "no," when was the last day of work? \_\_\_\_/\_\_\_\_/\_\_\_\_

**FAX to:** 360-902-6100  
**Questions?** 1-866-406-2482, toll-free - or 360-902-4411  
(Or mail to address above.)

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## ► Stay at Work wage reimbursement: What does it cover?

50% of your injured worker's **base wages**:

- For up to **66 days** in which work was actually performed. (*Fewer than 8 hours still counts as one day.*)
- Within a consecutive, 24-month period.
- Up to \$10,000 per claim.

**Important:** Base wages can't include tips, commissions, bonuses, board, housing, fuel, health care benefits (including dental and vision), per diem, reimbursements for work-related expenses, or any other payments. A paid leave day cannot be reimbursed.

## ► To be eligible for this program, the employer must:

- Have a description for the available, transitional or light-duty job that clearly indicates the physical requirements for the specific job.
- Have written approval from the worker's health care provider.
- Be the employer at the time of injury on the claim or, for an occupational disease claim, be the last employer to employ the worker when the claim was filed.
- Continue any health care benefits the worker had, unless these benefits are inconsistent with the employer's current benefit program for workers.
- Be paying workers' compensation premiums to L&I. (**Program not available for self-insured employers.**)
- Apply *within one year* of incurring the eligible expenses.

## ► Three required attachments for this form:

**Important:** Write the L&I claim number on each attached page

**❶ Payroll information:** Copy of payroll records for time period the employee worked the light-duty or transitional job.

**❷ Provider's description of the physical restrictions** preventing the worker from doing his/her usual work, *such as the APF\* or copy of chart note.*

*\*Activity Prescription Form*

**❸ A completed, light-duty or transitional job description** approved by the health care provider.

You may use the:

- Standard job description form (F252-040-000):  
[www.lni.wa.gov/FormPub/Detail.asp?DocID=1684](http://www.lni.wa.gov/FormPub/Detail.asp?DocID=1684)
- Or
- The return-to-work job description your organization currently uses with L&I.

## Instructions for sending this application to L&I:

- **Print your completed form.**
- **Sign.**
- **Gather required documents.**  
(Write claim # on each page.)
- **FAX form and all documents to:**  
**360-902-6100**  
(Or mail to address on pg. 1.)

## Questions? We can help:

**Call:** **1-866-406-2482**, toll-free  
or **360-902-4411**

**Or go to:** **StayAtWork.Lni.wa.gov**